HCC Benefits Corporation
401 Edgewater Place, Suite 400, Wakefield, MA 01880. Telephone: (781) 224-4300. Fax: (781) 245-1042

SPECIFIC CLAIM NOTIFICATION/INITIAL FILING

X CLAIM NOTIFICATION ____ INITIAL CLAIM

Account Information
Plan Sponsor Fulton Chevrolet/HighPoint Chevrolet Carrier AVEMCO

Policy Year 04/01/02-03/31/03 Contract Basis 15/12 Specific Deductible $ 20,000

Employee Information
Last/First Sikorski, John J Social Security Number 052-66-0287

Date of Birth 08/31/1966 Date of Hire 12/11/00 Original Effective Date 02/01/2001

What is employee's work status?
X Actively working the required number of hours per week to be considered full-time
___ Retired on _____
___ Disabled and has been out of work from _____ to _____

Coverage is being continued by the following: (complete as applicable)

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Sick Time _____ to _____ Vacation Time _____ to _____ MLA _____ to _____
Leave of Absence _____ to _____

___ Terminated coverage on _____ Is COBRA applicable? _____

COBRA effective date _____ COBRA termination date _____

Claimant Information
Last/First Sikorski, Catherine Date of Birth 05/29/1967 Relationship spouse

Sex F Original Effect 01/01/02 Termination Date n/a

Is COBRA applicable? _____ COBRA effective date _____ COBRA termination date _____

(If filing an Initial claim, include COBRA Election form & complete premium verification)

Is the Claimant covered by any other insurance plan? _____ (Auto, Worker's Comp., Group Plan)

Please provide details _____ Eff. date _____ Carrier _____

Eligible for Medicare? n/a Eff. date _____ Disabling condition if under 65 _____

Is Pre-X applicable? no Condition _____
Please provide Pre-X/HIPAA documentation

Claim Data
Diagnosis seizure disorder Prognosis negative response to brain surgery

If injury, when, where, & how did it occur? _____

HIGHPOINT CHEVROLET
HIGHPOINT CHEVROLET
Plan 65 102

SIBRA LTD
Claim Payment Detail

6/06/02 15:38:19 ZO11021
CUMULATIVE Reporting

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Claim Number	Employee SSN	Claimant Name	Employee Name	Emp/ Dep	Nature	Pay Code	Dates Incurred	Date Paid	Check Number	Pay Code Amount	Total Amount	Hosp Days	Payee
SIKOR0066010200202M007	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	44	12245	3/04/02	4/04/02	41595	101.47			EPILEPSY & NEUROP
SIKOR0066010200202M008	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	44	12204 913	3/05/02	4/18/02	42212	13,[illegible]50 1,[illegible].22-		10	ST AGNES HOSPITAL
SIKOR0066010200202M009	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	44	2240	4/01/02	4/25/02	42516	88.00			EPILEPSY & NEUROP
SIKOR0066010200202M010	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	124	2257	3/05/02	5/16/02	43432	621.29			MULTIPLAN INC
SIKOR0066010200202M011	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	92	12240	5/06/02	6/06/02	44234	134.00			ROSENBLADK MD, BA
SIKOR0066010200202M012	052660287	CATHERINE V SIKORSKI	JOHN J	SPOU	43	12245	5/05/02	6/06/02	44239	690.00	14,560.14		ATLANTIC OPEN MRI
							Medical Claim Total				14,560.14		
							Division Total				14,560.14		
							Plan Total				14,560.14		
					Plan Summary/								
30 Days 60 Days 90 Days Over 90 Ave # Days					Age 1				LOS 10.0		Total 14,560.14		
88.00 11,852.85 2,619.29 .00 18.8													

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From: KATZ, Kate Rogers 4/11/02 11:11a
To: KAREN, Karen Baxendale Fulton

we have a stop loss claimant-Catherine Sikorski who has a 13,000.00 dollar hospital stay with potential more to come. She is a spouse-052-66-0387 with the dx of seizure disorders. she had brain surgery to correct it and now it is not working. Shes only in her 30's.

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HCC Benefits Corporation

4 Independence Place, Suite 422, Westfield, Massachusetts 01085, Telephone (781) 224-1552, Fax (781) 245-4243

Subrogation applicable? _____ Please provide details _____

Primary Physician _____ Telephone # _____

Has Large Case Management been implemented? yes _____ Vendor HealthBest
$ 15,517.36 included NYHCRA surcharge

Claims Paid YTD $_____ Claims Pending YTD $ _____ Future Liability YTD$_____

If filing for Initial Claim Submission

Total TPA Paid	$_____
Less Specific Deductible	$_____
Payment Requested	$_____

If this is an initial claim submission, I hereby certify that, to the best of my knowledge, after reasonable inquiry; (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Plan Sponsor Benefit Plan; (3) that all the indicated expenses have actually been unconditionally paid by, or on behalf of the Plan as required by the Stop-Loss Contract, except as specifically disclosed in the attached Simultaneous Funding form, if any.

Claims Administrator: SIERA, LID

Address: 111 Grant Ave., Ste 100, PO Box 5000 , Endicott, NY 13671-5000

Phone:(607) 786-3003 ext. 330 Fax:(607) 786-3537

Completed By: Karen Baxendale

Date: 6-16-02

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Cumulative Claim Payment Detail Report Parameters

Beginning Plan	66	102
Ending Plan	66	102
Beginning Claim Division		
Ending Claim Division		99990
Beginning Basic Paycode		
Ending Basic Paycode		99999
Beginning Major Medical Paycode		
Ending Major Medical Paycode		99999
Beginning Credit 1 Paycode		
Ending Credit 1 Paycode		99999
Beginning Credit 2 Paycode		
Ending Credit 2 Paycode		99999
Beginning Nature Code		
Ending Nature Code		99999
Beginning Paid Date		40102
Ending Paid Date		60702
Beginning Incurred Date		10102
Ending Incurred Date		33103
Least Total Claim Dollar To Include		
Beginning EDS Name		SIKOR
Ending EDS Name		SIKOR
Beginning EDS Code		2
Ending EDS Code		2